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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Guinea

The Executive Director recommends that the Executive Board approve the country programme of Guinea for the period 1991-1995 in the amount of $9,250,000 from general resources, subject to the availability of funds, and $15,250,000 in supplementary funds, subject to the availability of specific-purpose contributions.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

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THE SITUATION OF CHILDREN AND WOMEN

1. Guinea emerged from 26 years of totalitarian rule in 1984. Since then, the Government has taken various measures to create a climate conducive to socio-economic development. But, the legacy of a quarter century of State control of every aspect of life, with the resultant inefficiency, decayed infrastructure and collapse of health and other social services, is proving difficult to surmount.

2. Since 1985, economic reconstruction has been a top government priority. Supported by the International Monetary Fund (IMF), the International Bank for Reconstruction and Development (IBRD), the African Development Bank (AfDB) and bilateral donors within the context of a structural adjustment programme, the first step was to create a financial, economic and administrative framework backed up by investment in infrastructure to achieve economic growth. Between 1986 and 1989, the economy is estimated to have grown at an average annual rate of 4.2 per cent, compared with a population growth rate of 2.8 per cent per annum. The total value of exports rose from $484 million in 1986 to $631 million in 1989. Guinea produces 14 per cent of the world's bauxite, making it the second largest exporter of the mineral, and the industry accounts for 87 per cent of the country's export earnings and employs 6 per cent of its active population. The State is dependent upon this single industry for 50 per cent of its budget, making it highly vulnerable to price fluctuations. Gold and diamonds account for 8 per cent of the total value of export earnings. As a result of various debt rescheduling exercises and debt forgiveness, Guinea was able to reduce its debt service burden from 26 per cent of export earnings in 1987 to 20 per cent in 1989. Total debt as a proportion of the gross national product decreased slightly, from 82 to 79 per cent, during the same period.

3. Although the Government has accepted policies advocated by UNICEF to mitigate the adverse effects of the structural adjustment programme upon the most vulnerable groups, this has not been reflected in the allocation of resources. The main tangible progress has been in government adoption of the Bamako Initiative, which has extended basic health services to one half of the population, and in the additional recruitment of health and education staff in the face of retrenchment in other sectors. However, at 2.5 and 13.4 per cent, respectively, in 1989, the health and education budgets are lower than the 1985 figures of 3.4 and 14 per cent, respectively. The impact of the average 40 per cent increase in prices between 1987 and 1989 on the 75 per cent of the urban population living below the poverty line remains unmitigated. The extent of this poverty is highly visible in Conakry, with its dilapidated infrastructure, poor housing, lack of sanitation facilities and general state of degradation.

4. A Commission was set up in 1989 to draw up a constitution to lead the country to free elections within the context of a multi-party system in 1992. Once adopted and implemented, it will complete the process of decentralization of power. The lower echelons of this structure, especially the districts, subdistricts and villages, form the basis for community participation in health, water and sanitation projects. As a result of UNICEF advocacy, the Commission is considering including basic children's rights in the Constitution.

5. According to the Population Division of the United Nations Secretariat, Guinea's infant mortality rate (IMR) is 146 per 1,000 live births, and the under-five mortality rate (U5MR) at 248 per 1,000 live births places it among the very high U5MR countries. The three major causes of morbidity recorded in UNICEF-assisted health centres are malaria, diarrhoea and respiratory tract infections, which account for 76 per cent of all under-five illness. At 9 per 1,000 live births, Guinea has one of the highest maternal mortality rates (MMRs) in the world. This is due to a combination of factors, which includes poor pre-natal care and the cultural values among certain ethnic groups that a woman should be able to deliver her baby unaided. Even where health centres exist, women are reluctant to leave their homes to attend pre-natal clinics. It is estimated that 90 per cent of Guinean women undergo harmful sexual mutilations. Goitre and other complications caused by iodine deficiency are very high throughout the country, with the exception of Guinea Maritime. The reported total of deaths caused by acquired immunodeficiency syndrome (AIDS) since 1987 is relatively low. Of those deaths, seven were children below the age of five years. The low figures are explained by the isolation of Guinea until 1985, but there are reasons for concern since there is evidence that the virus has spread throughout the country. A survey by the recently created AIDS Prevention Unit projected 0.9 per cent of the population as being infected with the human immunodeficiency virus (HIV).

6. The scant data available on the nutritional status of children indicate that certain regions are more affected by malnutrition than others. In particular, a recent survey of the Forest Region, where there has been an influx of refugees, showed that 7 per cent of children were affected by severe malnutrition. A preliminary survey at Conakry indicated that 2 per cent of the children are suffering from acute malnutrition, but this figure is likely to be higher as it accounts for 2 per cent of deaths in the city's hospitals. Various surveys are under way that should soon give a better nutritional profile of Guinean children.

7. Guinea is also known as the watershed of West Africa as the sources of the region's major rivers (Niger, Senegal and Gambia) originate from the country. Paradoxically, in spite of this abundance of rivers and streams, only 30 per cent of the rural population had access to safe drinking water in 1989. Although the urban population is slightly better off, with 39 per cent having access to tap water, its quality is not reliable. Sanitation and hygiene are very poor, particularly in urban areas where excreta disposal poses serious health threats to children. In Conakry and the Forest Region, the use of latrines is not considered a hygienic practice. These factors combine to cause a high rate of diarrhoea and other water-borne diseases, except for dracunculiasis (Guinea worm), which, despite its name, appears to have been eliminated.

8. While some progress has been made in the provision of health services and clean water since 1984, the education system remains untouched. Today, the level of illiteracy stands at 74 per cent. The female illiteracy rate is 83.3 per cent, while the rate for males is a much lower 62.2 per cent. In 1987-1988, primary school admission stood at 35.2 per cent, compared with 50.5 per cent in 1984-1985. School attendance is 17 per cent in rural areas. Although 51.3 per cent of the population are females, only 33 per cent of primary

school pupils are girls. Salaries account for 92 per cent of the national education budget, and at Conakry, the teacher/pupil and class/pupil ratios stand at 1:66 and 1:77, respectively. Such a situation is aggravated further by the low quality of the infrastructure, unqualified teachers and lack of teaching materials.

9. Radio reaches less than 20 per cent of the population and television is primarily an urban media. Newspapers are accessible only to a small elite. Hope for the future lies in the establishment of rural radio stations and in the more effective use of traditional channels of communication.

PROGRAMME CO-OPERATION, 1987-1990

10. The overall objective of the programme was to reduce IMR and to raise health and development levels in young children. The programme strategy aimed at improving institutional capacity and upgrading and progressively expanding basic services. The major consideration in the strategy was community participation and management of services, coupled with the efficient use of resources. Close collaboration between UNICEF and other partners constituted the major elements of the country programme strategy.

Health

11. At the start of the programme, health centres attracted only a small percentage of the population because they were in poor condition, underequipped and lacked medical supplies. Less than 10 per cent of the children under one year old were fully immunized against the six expanded programme of immunization diseases. Between 1987 and 1990, UNICEF, in close collaboration with the Government, donor agencies and non-governmental organizations (NGOs), established the basis for a national capacity to plan, monitor and evaluate implementation of the integrated primary health care (PHC) programme. This was achieved through the training of a wide range of health personnel at all levels. In collaboration with the State Secretariat for Decentralization, management committees have been trained to budget and participate in the administration of health centres. This intensive training and other institutional support, combined with the supply of essential drugs and other health materials, have resulted in the revitalization of health centres in 185 out of 350 subdistricts. Thus, about half of the 2,800,000 people living in those areas now have access to quality integrated curative and preventive health care. This includes the immunization of children and women, the protection of pregnant and lactating women, curative care based on essential drugs and growth monitoring of children under five years old. Sustainability is assured by community participation and co-financing using management committees. Regular monitoring and evaluation have shown that health centres are viable provided that support is maintained until a health system is firmly established.

12. Although the integrated approach to providing PHC has made great strides in putting the necessary systems and structures in place, it will take time for universal child immunization to be achieved through improved access to immunization and regained confidence in the health system by the population. The vaccination coverage for the first generation of 98 health centres in 1990 was 60 per cent with

anti-tuberculosis vaccine, 53 per cent with measles vaccine and 35 per cent with three doses each of combined diphtheria/pertussis/tetanus and polio vaccines. Coverage with two doses of tetanus toxoid for pregnant women stood at 45 per cent for 1989. This compares favourably with an average of less than 10 per cent of children fully immunized in rural areas not covered by the programme. The Bamako Initiative offers the perspective for further increasing and sustaining coverage. Conakry, with 19 per cent of the population, experienced a sharp increase of vaccination coverage from 4 to 56 per cent from 1986 to 1987. This declined to 19 per cent when the campaign approach was not sustained. Steps are now being taken to reform the urban health care system according to Bamako Initiative principles in order to ensure more sustained health coverage.

13. The use of oral rehydration therapy (ORT) is estimated at a disappointing 15 per cent, well below the 60 per cent targeted in 1986. The shortfall is due to the insufficient training of paramedical staff and the unavailability of services to 50 per cent of the population, even in areas with revitalized functioning health centres.

14. Low salary levels provoke a lack of motivation of health personnel, making it difficult to recruit health workers for remote areas. This is likely to be accentuated as the programme expands to the periphery. A recent study has shown that 47 per cent of the population live within a radius of 5 kilometres from a health centre, while 89 per cent are within 10 kilometres. Access to immunizations, however, has been increased recently through outreach from health centres.

Water and sanitation

15. UNICEF and other agency assistance in the field of water and sanitation contributed to an increase in the availability of drinking water from 17 to 34 per cent of the population from 1986 to 1989. UNICEF financed the drilling of 225 wells and the capping of 460 springs, benefiting 240,000 people. Institution building, technical assistance and logistics to reinforce the capacity of the Service National d'Aménagement des Points d'Eau (National Water Authority) to train local committees and to maintain and finance repairs of water points were also provided. Some 200 demonstration latrines have been constructed near health centres, schools, mosques and other public places with the support of a health education programme. While communities have participated readily in the water programme, involvement in sanitation projects has been more difficult to obtain. However, the current programme has laid the necessary base for a more effective sanitation intervention in the future.

Basic education

16. Effective UNICEF assistance in this sector began only in 1989 with the development of a national education policy. Technical assistance was provided to literacy, child-to-child and early childhood development programmes, and some 200 teachers and aides were trained in 10 experimental schools. A feasibility study will determine the viability of going-to-scale in the next programme of co-operation.

Decentralization and micro-projects

17. This programme aimed at reinforcing the capacity of the Department of Decentralization to develop a national strategy for micro-projects and to create a fund to finance small projects benefiting women. Some 100 staff at national, regional and prefectoral levels were trained in planning and monitoring micro-projects. It has also assisted NGOs involved in household food security for 1,000 families and supported 26 small income-generating projects benefiting 600 families. Moreover, it has been catalytic in encouraging the United Nations Development Programme (UNDP), IBRD, the United States Agency for International Development (USAID), the Canadian International Development Agency (CIDA) and other donors to participate in the programme. UNICEF advocacy efforts have culminated in the creation of a local development project fund for micro-projects as an incentive for community participation.

Social dimension of adjustment

18. UNICEF provided technical assistance to an intersectoral working group on mitigating the impact of structural adjustment. This has led to the creation of a unit responsible for monitoring and evaluating the social impact of adjustment and recommending mitigating actions. UNICEF participation has decreased during the latter part of the programme, but steps have now been taken to use this unit as an additional channel to monitor and advocate on behalf of mothers and children.

Emergency assistance

19. The influx of 80,000 refugees at the beginning of the civil war in Liberia in early 1990 increased to some 300,000 by mid-1990. UNICEF and the European Economic Community (EEC) were the first multilateral organizations to respond to the emergency by providing essential drugs, vaccines and logistical support through Médecins Sans Frontières (Doctors without Borders) (Belgium). Further assistance was provided by protecting water points, drilling wells, constructing latrines and through health education. In addition to a swift response, UNICEF was catalytic in successfully advocating for assistance to both refugees and the local population who have generously shared their food and shelter with them. EEC and the Office of the United Nations High Commissioner for Refugees (UNHCR) have joined with UNICEF in providing 60 wells that will continue to serve the local population after the departure of refugees.

Lessons learned

20. The main strength of the Guinean programme is the result of government adherence to a process of adjustment with a human face, which, combined with a policy of participatory development, has created a climate conducive to the adoption of child survival and development (CSD) strategies. This opportunity has been seized to establish a co-financed and co-managed community recovery health care system and a water programme based on decentralization through community involvement. The results have clearly demonstrated that such an approach is not only feasible, but economically viable and expansion sustainable, even in a country with serious structural inadequacies, provided certain basic conditions are met.

In particular, it has required a considerable investment in human resources to build the necessary capacity at national, regional, prefectoral and sub-prefectoral levels. It has also demonstrated the need for constant monitoring and evaluation, not only to enable corrective measures and adjustments to be undertaken, but also as an important means of motivating all the participants involved in the process.

21. While the Government has adopted the appropriate CSD policies, such as the ratification of the Convention on the Rights of the Child, this commitment has not always been matched by the required resources being put at the disposal of the ministries involved in their implementation. Furthermore, constant advocacy at all levels is required to ensure that the necessary mechanisms are put in place to decentralize and transfer management control of health care to the community.

22. Programmes have been utilized where there is a felt need, such as in the provision of curative health care and the supply of clean water, and in the future, particular attention must be given to areas such as preventive medicine and sanitation where the causes and effects are not apparent. This is a major new programme challenge that has been responded to by strengthening social mobilization and health education to ensure that the long and arduous task of changing attitudes and practices is embarked upon in earnest. In this context, a CSD action group was set up to promote action for children. Past experience has shown that advocacy is a continuous process involving keeping abreast of events in order to seize upon the appropriate occasions to influence policies, change attitudes and generate action in favour of women, children and other vulnerable groups.

RECOMMENDED PROGRAMME CO-OPERATION, 1991-1995

Recommended general resources: $ 9,250,000
Supplementary funding: $15,250,000

Recommended programme co-operation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	3 900	6 155	10 055
Water supply, sanitation and primary environmental care	2 250	6 245	8 495
Education for all	1 350	1 100	2 450
Social mobilization and advocacy for child survival	1 100	700	1 800
Urban development	650	1 050	1 700
Total	9 250	15 250	24 500

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme goals and objectives

23. The main objective of the 1991-1995 programme of co-operation will be to support the implementation of government policies aimed at ensuring the survival, development and protection of children and mothers. An assessment of these policies, in conjunction with the strategies for children in the 1990s, has led the Government and UNICEF to adopt the following goals: (a) to reduce IMR to 100 per 1,000 live births, U5MR from 248 to 150 per 1,000 live births and MMR from 900 to 750 per 100,000 live births by 1995; (b) to provide 90 per cent accessibility to PHC services by 1995; (c) to ensure that 60 per cent of the rural population have access to 10 litres of safe drinking water per capita per day by 1995, combined with sanitation education; (d) to improve the quality and relevance of primary school curricula and learning materials, to assist in increasing school attendance from 28.6 per cent in 1989 to 40 per cent in 1995 and to reduce illiteracy from 74 to 60 per cent in 1995; and (e) to strengthen information channels to ensure that 75 per cent of all Guineans are aware of CSD skills and services.

Programme strategy

24. The strategy aims: (a) to advocate and carry out social mobilization activities to create a climate that is conducive to concrete actions for the survival, development and protection of children; (b) to consolidate the achievements of the previous programme of co-operation by increasing coverage effectiveness; (c) to support the decentralization process to ensure community involvement; and (d) to reinforce and upgrade national capacity, combined with effective community participation, to ensure sustainability.

Health and nutrition through the Bamako Initiative

25. The achievements of the programme of integrated PHC based on the Bamako Initiative will be consolidated and expanded both geographically and in scope. By the end of 1995, 90 per cent of the population will be covered by an integrated health programme that will provide pre- and post-natal care, immunization, the control of diarrhoeal diseases and essential curative care linked to nutrition, education, water and environmental sanitation activities. Within the subdistricts with functioning health centres, access will be increased from the current 47 to 90 per cent of the population and systems will be put in place to monitor and increase utilization of existing services. In addition, at least one health centre in each of the remaining subdistricts will be operationalized.

26. To consolidate the achievements to date, continued strengthening of institutional support through a system of community participation is needed. The efficiency of the services will be improved by more rigorous management, with particular attention being paid to the preparation and execution of health centre budgets and the rationalization of services offered. This will involve regular monitoring, evaluation and operational research. Particular attention will be paid to the financial viability of the programme through community co-financing. The implementation of the co-financing system for the first generation of 98 health centres shows that they are now in a position to start paying for their essential drugs and that the 79 second-generation centres should be in a similar position after two years of operation. However, logistical support, equipment and other materials will be required for a longer period of time. The low quality of referral infrastructures indicates that some technical and material assistance in this area will contribute to reaching adopted objectives.

27. Immunization and ORT will continue within the context of the integrated PHC system. The objective will be to increase and maintain immunization coverage at 75 per cent by 1995 for all antigens. This will be achieved by increasing the availability of centres, as well as through better training and mobilization of both health workers and the population to ensure daily vaccination services and full contact opportunities. As the current low vaccination coverage is mainly due to the high proportion of defaulters, the baby tracking system will be reinforced through the establishment of a community-based monitoring system. Although ORT is part and parcel of the integrated PHC system, its use nationally as a treatment for diarrhoeal dehydration amounts to only 15 per cent as a treatment. This component aims to reduce infant mortality caused by diarrhoeal dehydration through the correct administration of ORT in 80 per cent of child diarrhoea cases by 1995. To

achieve this objective, the education of health personnel in the programme will be strengthened, and there will be increased social mobilization activities. Steps will also be taken to involve traditional birth attendants (TBAs) in the use of ORT. Discussions are under way to initiate a joint ORT promotion programme with Population Services International, thus complementing the work currently being undertaken by USAID/Combating Communicable Childhood Diseases (CCCD).

28. Maternal health care will be reinforced by the training of an additional 3,500 TBAs in safe delivery skills. Some 350 midwives will be trained to ensure the proper training and monitoring of TBAs and to increase awareness of risk pregnancies, maternal health care, birth spacing and family planning. UNICEF will co-operate with other donors to renovate and upgrade maternal and child health wards at each of the district referral hospitals. A major social mobilization exercise will be launched to increase the number of pregnant women attending pre- and post-natal clinics to 80 per cent, to change traditional attitudes and practices that are detrimental to safe delivery and to increase awareness of the dangers of the HIV virus.

29. With regard to nutrition, emphasis will be placed on promoting prolonged breast-feeding, which is currently practised by 70 per cent of Guinean women. Since reports from health centres show that infants experience growth problems from six months onwards, rapid assessment procedures/knowledge, attitude and practice (RAP/KAP) studies will be undertaken to determine the specific local causes and actions will be programmed accordingly. Although the extent of malnutrition is difficult to quantify, the scant data available suggest that it is a problem that requires attention. A clearer picture will emerge once preliminary results of various studies currently under way become available, and these will be used to design preventive nutrition interventions. Particular attention will be paid to growth monitoring and promotion through community participation, using mothers as weight watchers as an integral part of the PHC system. The problem of iodine deficiency is evident by the large number of women with goitre throughout the country, except in Guinea Maritima. This situation was confirmed in a recent study by the Pasteur Institute, which showed that in some villages, 70 per cent of the population suffered from this micronutrient deficiency. A project is being prepared with the Government to identify the areas affected and to select various options to provide iodine supplements.

Water supply, sanitation and primary environmental care

30. UNICEF will continue its close collaboration with the Service National d'Aménagement des Points d'Eau and donor agencies in order to improve water supply and environmental sanitation. This assistance will aim to reinforce the capacity of the Service to plan, execute, monitor and evaluate rural water projects. It will also assist in the establishment of a system to control the quality of drinking water. Emphasis will be placed on technical and logistic assistance to the Service's Division of Maintenance, especially to inform and motivate the target population and to ensure community participation in the protection and upkeep of water points. This programme will assure clean drinking water for 390,000 people, or an additional 9.4 per cent of the rural population. Steps will be taken to obtain World Health Organization (WHO) confirmation that dracunculiasis has been

eradicated nation wide. In the area of sanitation, the main objective will be to build demonstration latrines in 120 health centres, 100 schools and 6 public places and to guarantee their proper use and maintenance through community participation and health education. The primary environmental care component is experimental, linked closely to the water and sanitation programme, and aims to protect the immediate environment through community actions.

Education for all

31. The programme will support government efforts to increase the school attendance rate and its literacy programme. It will also support six experimental community projects through which children both in and out of school can acquire life skills. This approach is necessary to complement the efforts of various donors by increasing the absorption capacity of the Department of State for Pre-University Education and by developing new approaches to basic education. This supportive role is essential as various donors, in particular USAID, IBRD and the Governments of Canada and Japan, have agreed to support basic education projects. This will be done with technical assistance to increase the ability of the Department to plan, execute and monitor projects. It will also support department efforts to strengthen data collection and analysis. A project aimed at early childhood education through community participation will be put into place. The necessary structures and systems for the care of 100,000 pre-school children through 500 child-care community groups will be set up. UNICEF support of functional literacy will provide 350,000 women and girls with the training needed to enable them to acquire basic skills at 350 experimental functional literacy centres, promoting research and action to enhance their living conditions and those of their children.

Urban development

32. The poor environmental conditions of 75 per cent of Conakry's population living below the poverty line demand concerted action by the Government, the local administration, religious leaders, NGOs and donor agencies. UNICEF will work closely with all those partners to improve the situation. In particular, it will reinforce the large urban projects being implemented with actions at the local level to ensure community participation to mitigate the negative social effects of capital intensive urban projects. In close collaboration with the Ministry of Urban Planning and other UNICEF programmes in health, education, water and sanitation supported by social mobilization, UNICEF will promote an integrated approach for providing basic services at the community level. The success of such an approach can serve as a model for wider use.

Emergency response to children in difficult circumstances

33. The influx of 300,000 Liberian refugees has enabled UNICEF to gain experience in emergency situations that can be used to protect women and children in Guinea. Such situations call for quick, concerted action with the Government and various international agencies. UNICEF programmes in health/nutrition and water and sanitation give an on-the-spot capacity to react promptly to emergencies. Monitoring capacity to assess the impact of any emergency on the health and

nutritional status of mothers and children will be maintained to enable the necessary corrective actions to be taken.

Advocacy and social mobilization

34. Social mobilization is an essential process that will be fully exploited to ensure that transmitted messages result in concrete actions for CSD. It is imperative that this mobilization utilizes all means and methods of communication, in particular traditional and interpersonal channels. This approach is even more important because the modern media is accessible to less than 20 per cent of the population. This approach will increase the utilization of health centres for preventive care, as well as the level of school attendance in general and of girls in particular. It will also ensure a more effective use of water points and sanitation facilities. Ultimately, social mobilization will be used to obtain the synergistic benefits of UNICEF programmes in Guinea to ensure that at least 75 per cent of the population is informed and utilizes the CSD services provided.

Monitoring and evaluation

35. A co-ordination commission will be created to monitor programme implementation. An annual review will be undertaken during the last quarter of each year to examine implementation of the annual current plans of action and approve those for the coming year. Programme evaluation will be based on regular monitoring and evaluation reports, data from the National Information and Statistics System and from RAP/KAP studies. There will be a mid-term review in 1993, and a final evaluation of the country programme will be undertaken in 1995. Continuous updating of the situation analysis will permit the regular publication of sectoral monographs, as well as a revision of the situation of women and children in Guinea in 1994.

Co-operation with the United Nations and other organizations

36. UNICEF will continue to work closely with other agencies to achieve the national goals for the 1990s. In particular, the health and nutrition programme requires close collaboration with WHO, the United Nations Population Fund (UNFPA), the World Food Programme (WFP), UNDP, IBRD, AfDB, the German Agency for Technical Co-operation, CCCD and NGOs such as Médecins Sans Frontières (Belgium), Medicus Mundi and Grupi Volontari Civili (Italy). Similarly, the water and sanitation programme is financed jointly by EEC, the Islamic Development Bank, IBRD and UNHCR (in refugee areas). In the education programme, the main partners will be USAID, CIDA, IBRD, the Japan International Co-operation Agency and the United Nations Educational, Scientific and Cultural Organization (UNESCO). Now that IBRD and UNDP are financing micro-projects, past UNICEF experience will make a useful contribution to increase the chances of success of these interventions. Regular contacts will be maintained with other donors and visiting missions to ensure complementarity of action.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Guinea (1989 and earlier years) — UNICEF country classification

Under-five mortality rate	241	(1989)	Very high U5MR
Infant mortality rate	142	(1989)	Very high IMR
GNP per capita	$ 430	(1988)	Low GNP
Total population	6 million	(1989)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1989
Births	(thousands)	210	227	251	278
Infant deaths (under 1)	(thousands)	38	37	38	39
Under-five deaths	(thousands)	65	62	65	67
Under-five mortality rate (per 1,000 live births)		309	275	260	241
Infant mortality rate (under 1) (per 1,000 live births)		182	162	151	142

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987)	Moderate & severe	..	..
	Severe	..	..
Babies with low birth weight (%, 1979/1987)		18	25*
Children completing primary level (% of first grade, 1980/1986)		..	70

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1986)	100*/ 70*/ 40*	100*/ 90*/ 85*
Prevalence of wasting (%, 1980/1985)	..	..
Prevalence of stunting (%, 1980/1985)	..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)	79	77
Food production per capita index (Index 1979-1981=100, 1980/1989)	102	88
Household expenditure (% of total income, 1980-1985) — All food/cereals		../..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987-1988)			1
Access to health services (% of population, 1980/1985)	Total	..	47
	Urban/rural	../..	100/ 40
Access to safe water (% of population, 1980/1985)	Total	17	38*
	Urban/rural	69/ 2	65*/ 30*
Access to adequate sanitation (% of population, 1980/1987)	Total	14	..
	Urban/rural	54/ 1	../..
Births attended by trained personnel (%, 1980/1988)		..	25
Maternal mortality rate (per 100,000 live births, 1979/1987)		..	800*

Immunization		1981	1985	1988	1989
One-year-olds (%) immunized against:	Tuberculosis	4	..	31	..
	DPT	..	..	16	..
	Polio	..	..	16	..
	Measles	15	4	27	..
Pregnant women (%) immunized against	Tetanus	5	5	6	..

/...

TABLE 1 (continued)

Guinea

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	32/ ..	30/ 23
	Male	42/ ..	42/ 31
	Female	21/ ..	19/ 15
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	14/ ..	9/ 6
	Male	21/ ..	13/ 9
	Female	8/ ..	4/ 3
Adult literacy rate, 15 years & older (%, 1970/1985)	Total	14	17
	Male/female	21/ 7	26/ 8
Radio/television sets (per 1,000 population, 1980/1988)		30/ 1	34/ 3

DEMOGRAPHIC INDICATORS		1970	1980	1985	1989	2000**
Total population	(millions)	3.9	4.5	5.0	5.6	7.8
Population aged 0-15 years	(millions)	..	2.4	2.4	2.7	4.1
Population aged 0-4 years	(millions)	..	0.9	1.0	1.1	1.6
Urban population (% of total)		14	19	22	25	33
Life expectancy at birth (years)	Total	37	40	42	43	48
	Male	36	39	41	43	47
	Female	37	40	42	44	48
Total fertility rate		7.0	7.0	7.0	7.0	6.8
Crude birth rate (per 1,000 population)		52	51	51	51	49
Crude death rate (per 1,000 population)		28	25	23	22	18

		About 1980	Most recent
Contraceptive prevalence rate (%, 1976/1987)		1	..
Population annual growth rate (%, 1965-1980/1980-1989)	Total	1.9	2.5
	Urban	6.6	5.6

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1988)		1.3	..
Inflation rate (%,1965-1980/1980-1988)		3	..
Population in absolute poverty (%,1977/1988)	Urban/rural	../..	../ ..
Household income share (%,1977/1988)	Top 20%/bottom 40%	../..	../ ..
Government expenditure (% of total expenditure, 1980/1987)	Health/education	../ ..	3*/ 11*
	Defence	..	29*
Household expenditure (% of total income, 1987)	Health/education		14*/ 1*
Official development assistance: (1980/1988)	$US millions	90	262
	As % of GNP	6	11
Debt service (% of goods & services exports, 1980/1988)		..	22

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1990

(In thousands of United States dollars)

COUNTRY: GUINEA
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: $5,765,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	867	936	92	323		563	255	1249	1214	3071	4285
Water supply and sanitation	1579		51		126		184		1940		1940
Nutrition			4				2		6		6
Education	62		26		14		150		252		252
Community organization and development	111		57	20			150	42	318	62	380
Women-centred programme	30		15				5		50		50
Planning and project support	159		6		900		408	3	1473	3	1476
Freight	177	5							177	5	182
GRAND TOTAL	2985	941	251	343	1040	563	1154	1294	5430	3141	8571

GR = General resources.
FSF = Funded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1991-1995

(In thousands of United States dollars)

Country: GUINEA Period covered: 1991-1995	Funding status	1991	1992	1993	1994	1995	Total
Health	GR	830	830	780	730	730	3900
	FSF	1822					1822
	NSF	1025	1625	1325	1310	870	6155
Water supply and sanitation	GR	450	450	450	450	450	2250
	NSF	450	1650	1500	1400	1245	6245
Education	GR	250	250	250	300	300	1350
	NSF		200	300	300	300	1100
Social mobilization and advocacy	GR	220	220	220	220	220	1100
	NSF	50	150	150	150	200	700
Integrated area-based programme	GR	100	100	150	150	150	650
	NSF	100	200	250	250	250	1050
TOTAL	GR	1850	1850	1850	1850	1850	9250
	FSF	1822					1822
	NSF	1625	3825	3525	3410	2865	15250
GRAND TOTAL		5297	5675	5375	5260	4715	26322

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: GUINEA	Number of posts	Amount (thousands of United States dollars)
FINANCED FROM 1992-1993 PROPOSED BUDGET:		
International Professional established posts	3	671
Local national Professional and General Service established posts	6	301
Operating costs		734
Total	9	1706
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	3	655
Supplementary funds	2	452
Local national Professional and General Service project posts		
General resources	18	605
Supplementary funds	7	202
Total	30	1914

a/ For information source, see 1992 post authorization table, dated January 1991.